KANSAS LONG-TERM CARE OMBUDSMAN
ANNUAL REPORT Year 2022
Oct. 1 2021 - Sept. 30 2022

Recognizing and Respecting Individuality

Advocacy

Education

Empowerment

Kansas
Department of Administration
Office of the State
Long-Term Care Ombudsman

Dear Fellow Kansans,

The Long-Term Care Ombudsman Program (LTCOP) is a historical model for the doctrines of person-centered care required in nursing homes. The tenants of the Ombudsman program have long recognized and respected the resident as the driving force in knowing what is uniquely necessary for them to live their best life. Ombudsmen promote and protect the residents' right to maintain dignity; be free from abuse, neglect, or exploitation (ANE); maximize independence, autonomy, privacy; and have meaningful relationships.

Far too many of our fellow Kansans are not living their best life. Residents often express resignation over slow or outright lack of response when needing help, even basic care, or having proper food and drink. Symptoms and situations of ANE sometimes go unaddressed, unrecognized, and unreported.

Residents expressing behavioral communication that staff should recognize as distress and symptoms of possible abuse or neglect are unjustly characterized as hostile or being difficult. Some staff report to Ombudsmen they do not know protocols for reporting abuse or neglect. Coordination to systemically address prevention, intervention, and provide post-trauma support of ANE is lacking.

It is important to note that while the Ombudsman program data shows significant quality-of-care and quality-of-life concerns, the numbers collected for the National Ombudsman Reporting System reflect only a fragment of the number of individuals personally experiencing these adverse situations.

The unique nature of the LTCOP requires Ombudsmen to provide confidential interaction and action only upon the residents' direction. Because of this, residents typically trust Ombudsmen, and sometimes even share information they may not have shared with anyone else. Ombudsmen are not therapists, but interaction with residents can often be therapeutic because of the emotional safety the program provides. Building trust and providing information to empower residents often allows them to address their own concerns. It also allows ombudsmen to learn of widespread conditions in a home that they then can work to resolve on behalf of all residents.

In recent years, residents have expressed greater fears than ever about retaliation. Residents afraid of retaliation often resign themselves to having been heard by the Ombudsman but will not allow the Ombudsman to address their concerns. These situations are not reflected in individual cases or complaint numbers.

The program is small; yet charged with a significant amount of responsibility. Each person working within the program is dedicated to serving and supporting residents. Each Ombudsman is diligent in their efforts.

In the following pages, you will find data, findings, and outcomes regarding the types of problems experienced and complaints received from, or on behalf of, residents. Also included in this report are policy, regulatory, and legislative recommendations to provide solutions for common problems and complaints with the goal of improving the quality of care and quality of life for residents, ultimately impacting all Kansans.

It is an honor to serve,

Camille K Russell

Kansas State Ombudsman

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Program Authority and Structure

Authority and Structure

The Kansas Long-Term Care Ombudsman Program is authorized by the federal Older Americans Act (OAA) of 1975; 42 U.S. Code, Section 3058g and the Kansas Long-Term Care Ombudsman Act K.S.A. 75-7301 et seq.

Through federal and state law, Kansas' Long-Term Care Ombudsman program is responsible for advocating for residents of long-term care facilities, including nursing homes, assisted living facilities, home pluses, residential care facilities, and boarding care homes. The Kansas Long-Term Care Ombudsman Act gives the Long-Term Care Ombudsman Office authority to work with residents in all Kansas Adult Care Homes as defined in K.S.A. 39-923, and amendments thereto, except for any nursing facility for mental health or any intermediate care facility for people with intellectual disabilities.

The Office of the State Long-Term Care Ombudsman operates as a separate agency within The Office of Public Advocates and is attached to Kansas Department of Administration.

- The State Ombudsman, appointed by the Governor and confirmed by the Senate, coordinates ombudsman services provided by the Office across the state.
- An Administrative Specialist provides support to the program.
- Regional Long-Term Care Ombudsmen (7), of what had once been nine (9), work to serve residents living in over 700 adult care homes across our 105 counties.
- A Special Projects Ombudsman, currently funded by one-time COVID-19 funding.
- A part-time Person-Centered Mentor Trainer, currently funded by one-time COVID-19 funding.
- Certified Ombudsman Volunteers (13) are independent citizen advocates who listen to and address the concerns of residents living in long-term care facilities. Volunteers must be at least 18 years old, have available transportation, and be able to pass a criminal records check and the conflict of interest screening. The availability to attend 36 hours of initial training and 18 hours of continuing education annually is required.

Kansas
Department of Administration
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Long-Term Care Ombudsman

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Supporting
Quality of Life

Responsibilities

Federal and state law sets forth the responsibilities of the Office and Ombudsmen. Among the responsibilities are to:

- Identify, investigate, and resolve complaints made by, or on behalf, of individuals receiving long-term care in a facility.
- Provide services to individuals receiving long-term care to assist in protecting the health, safety, welfare, and rights of those individuals.
- Ensure that residents have regular and timely access to Ombudsman program services.
- Represent the interest of individuals before governmental agencies and seek administrative, legal and other remedies to protect the health, safety, welfare and rights of those individuals.
- Provide information to the public regarding problems and concerns of individuals receiving long-term care, including recommendations related to such problems and concerns.
- Analyze, comment on, and monitor the development and implementation of laws, regulations or policies pertaining to the health, safety, welfare, and rights of individuals receiving long-term care services.
- Provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

An Ombudsman is an independent resident advocate.

Ombudsmen investigate complaints concerning the health, safety, welfare and rights of long-term care residents, and work to resolve these complaints to the satisfaction of the resident.

The word "ombudsman" is Swedish and means "one who speaks on behalf of another." The Ombudsman is an advocate for residents of long-term care facilities.

Overview of the Program's Service to Kansans

Between October 1, 2021– September 30, 2022, the Kansas Long-Term Care Ombudsman Program:

- Investigated 1,128 complaints made by, or on behalf of, long-term care facility residents.
- Resolved, or partially resolved, 81 percent of these complaints to the satisfaction of the resident.
- Made 1423 facility visits to adult care homes to meet with residents and to be available to assist residents.
- Assisted 83 individuals subjected to involuntary discharges/eviction actions.
- Supported resident and family self-advocacy by attending and providing support to 93 resident and family council meetings.
- Provided information and assistance to 2,131 individuals on topics such as residents' rights, resident care, infection control guidance, and regulations.
- Provided information and assistance to 1,285 facility staff on topics such as residents' rights, resident care, family conflict, power of attorney, and the role and responsibilities of the Ombudsman program.
- Provided 27 community education sessions on long-term care issues.
- Held 26 virtual training sessions specific to Person-Centered Practices for 395 confirmed participants from facilities and the community.
- Completed training and certification of 1 new Regional Ombudsman and 2 new Volunteer Ombudsman.
- Provided information and advocated for residents with surveyors 319 times during facility surveys conducted by the state licensing agency (KDADS).

Complaint Investigation

Ombudsmen investigate complaints about violations of resident rights or quality of care on behalf of residents of adult care homes. Ombudsmen work directly with the resident to identify solutions and implement needed changes for their care, rights, or quality of life.

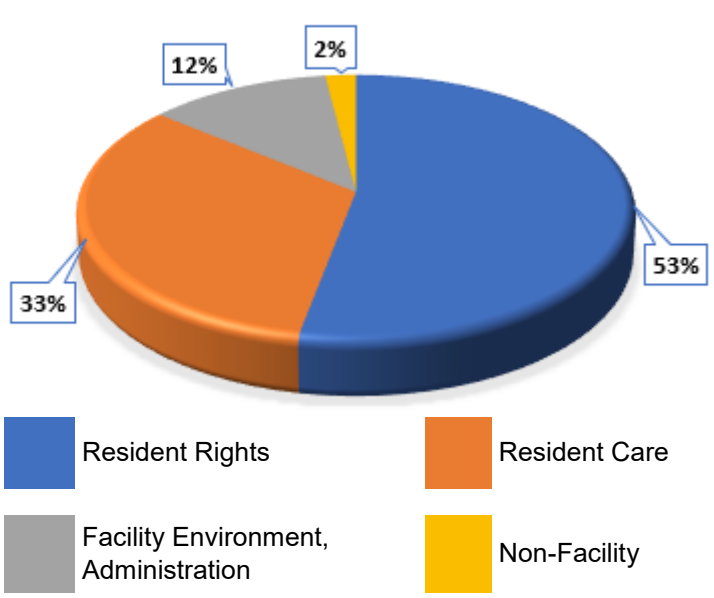
The goal of the Ombudsman's work, not regulatory in nature, is to resolve the concern to the satisfaction of the resident. Ombudsmen protect the confidentiality of the resident's information and do not take action on behalf of the resident without permission from the resident. Ombudsmen investigation focuses on identifying the problem and developing potential solutions. With the resident's permission, the ombudsman will review medical records, gather information from all parties, and observe the long-term care environment.

The Ombudsman meets with the resident to discuss and develop viable solutions to the resident's concerns. The ombudsman works collaboratively with residents, family, and providers to reach an effective resolution for all parties whenever possible, but is an advocate for the resident at all times.

In FY2022, the Kansas Office of the Long-Term Care Ombudsman received and handled 1,128 complaints. Ombudsmen are trained to handle many different types of complaints in long-term care settings, from the right to refuse medication to the right to be served by well-trained, competent staff.

The Ombudsman program defines 59 different complaints grouped into four categories: Resident Rights, Resident Care, Facility Environment & Administration, and Non-Facility.

The chart to the right shows the percentage breakdown of the total number of complaints investigated in each of these four categories in FY2022. The largest number of complaints handled during this reporting year concerned resident rights (53%) and the smallest number were non-facility complaints about administration (2%).



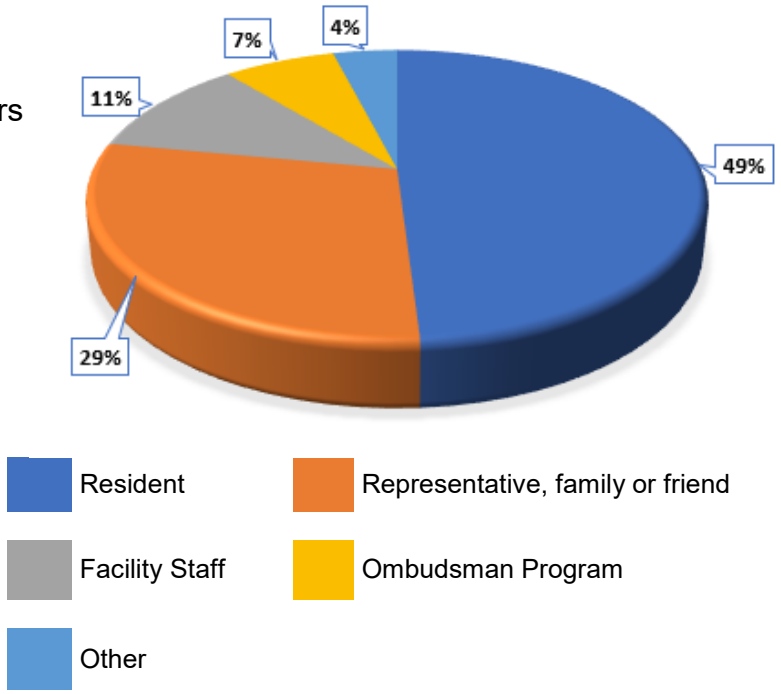
Numbers of Complaints Investigated by Category and Type of Complaint

Category and type of complaint	Number of complaints
Resident Rights: Abuse, neglect, exploitation	115
Resident Rights: Access to information	47
Resident Rights: Admission, transfer, discharge, eviction	99
Resident Rights: Autonomy, choice, rights, privacy	256
Resident Rights: Financial, property	87
Total Resident Rights Complaints	**604**
Resident Care: Care	287
Resident Care: Activities, community integration, social services	28
Resident Care: Dietary	57
Total Resident Care Complaints	**372**
Environment/administration: Environment	62
Environment/administration: Policies, procedures and practices	68
Total Environment/administration Complaints	**130**
Non- Facility: Outside agencies	5
Non - Facility: Systems, Others	17
Total Non-Facility Complaints	**22**
Total Complaints all Categories	**1128**

Complainants

Most complaints are made by residents themselves or their friends or relatives. However, many providers contact us because they recognize that residents need an independent advocate to make sure their concerns are heard and addressed. No matter who initiates the complaint, the program will respect the resident and the complainant's confidentiality, while focusing complaint resolution on the resident's wishes.

The chart to the right shows who made the complaints for all cases that were opened.

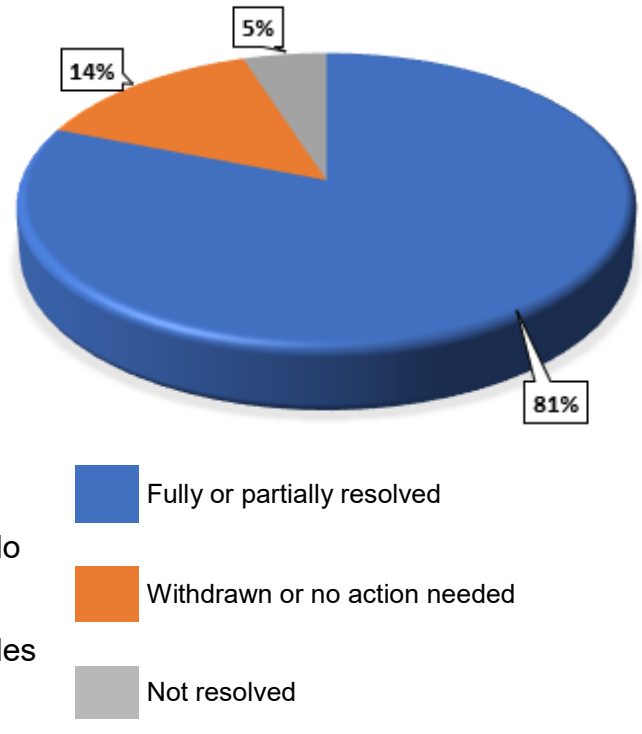


Complaint Resolution

A complaint is closed when there is no further action needed on the part of the Ombudsman. Each complaint is then assigned a disposition. A complaint is resolved when the complaint/problem is addressed to the satisfaction of the resident, or if the resident is not able to make their wishes known, the resident's representative or the complainant.

In FY2022, the Long Term Care Ombudsman Program resolved 81 percent of complaints to the resident's satisfaction. Not all complaints can be resolved to the satisfaction of a resident; for example, some complaints are referred to another agency for resolution and others do not require any action to be taken.

The chart to the right shows what types of disposition codes were assigned to closed complaints during the year.



Other Ombudsman Activities

Information and Assistance/Consultation

The Long-Term Care Ombudsman's Office provides information to residents, facilities, and providers. Requests for information are most frequently related to resident rights; choosing a nursing home; interpreting regulations; the abuse, neglect or exploitation of a resident; and admission and discharge procedures. Consultation does not involve investigating or working to resolve a complaint.

In FY 2022, Representatives of the Office **consulted with 2131 residents and 1,285 facilities or providers** about long-term care issues.

Resident and Family Councils

The Long-Term Care Ombudsman's Office assist resident and family councils by attending meetings upon request and providing assistance in the development and continuation of resident and family councils. Resident and family councils are meetings that give residents and their families opportunities to discuss issues, care needs, frustrations, and to receive support and encouragement.

In FY 2022, Representatives of the Office **worked with 90 resident councils and 3 family councils** across the state.

Community Outreach and Education

The Long-Term Care Ombudsman's Office conducts community outreach education in person and virtually. Ombudsmen provide education related to the rights of residents, how to advocate on behalf of or empower residents, the services of the ombudsman program, person-centered care practices, and elder abuse.

In FY 2022, Representatives of the Office **provided 27 community education sessions** about issues pertaining to long-term care across the state.

Survey Participation

The Long-Term Care Ombudsman's Office participates in survey activities conducted by the Department for Aging and Disability Services, which serves as the regulatory agency for long-term care facilities in Kansas to ensure their compliance with federal and state laws. The role of the Office is to provide comment, share concerns on behalf of residents, and family members and ensure the residents' voices are heard. Participation by the Office may include pre-survey briefings, attending resident interviews or the exit interview.

In FY 2022, Representatives of the Office **provided information and advocated for residents with surveyors 319 times** during facility surveys conducted by KDADS.

Issues

Quality of Care

287 CARE COMPLAINTS

Care complaints rose to the **highest level of complaint category** this program year.

The failure to identify, support, or provide services related to a change in resident's condition in numerous ways.

Examples include:

- Failure to address symptoms such as pain, skin integrity, pressure sores, fever, and infection.
- Healthcare providers were not notified of changes in resident condition.
- Resident representatives were not notified of changes in resident condition.
- Lack of monitoring and care for individuals, such as blood pressure or temperatures not taken.
- Dressings not changed for weeks.
- Individuals left laying in the same position without assistance to reposition for long periods.
- Changes in mental health or cognitive changes that would warrant further assessment were overlooked.

Staff with less training and experience, with fewer LPN or RN staff to look to for guidance and support, make for conditions are where poor care is more likely to occur. High staff turnover and higher rates of agency staff exist where residents and their specific needs and conditions are not known to the aids attempting to provide for their support and care. Basic care is difficult even with the best of intentions and true person-centered care is nearly impossible.

"My grandfather was recently admitted to the hospital from the nursing home with pneumonia. He was dirty, had not been showered, changed. He has open sores on his feet." - Family Member

Numerous studies of nursing homes reveal a strong, positive relationship between the number of nursing home staff who provide direct care to residents on a daily basis and the quality of care and quality of life of residents.

When I first came here 3 years ago, they had housekeeping staff. Now the aids are supposed to clean but they don't have time. They don't have time to help me use the bathroom and want me to wear briefs. I wait hours to get changed. They keep hiring less people but my bill doesn't go down.
- Resident

The Centers for Medicare & Medicaid Services (CMS) is expected to establish new minimum staffing requirements this spring, so every nursing home has sufficient staff who are adequately trained to provide the safe quality of care residents need. A 2001 CMS study found that nursing home residents require 4.1 hours per resident day (hprd) of direct nursing care to avoid being at an increased risk of harm. Kansas currently only requires 2.0 hours per resident day. Insufficient staffing equates to poor care, poor quality of life, and trauma for residents in nursing homes.

Issues

Insufficient Staffing

Nursing homes are currently required to have sufficient nursing staff with the appropriate competencies to assure resident safety and attain or maintain the highest practicable level of each resident's physical, mental, and psychosocial well-being. Complaints associated with insufficient staffing are pervasive.

> *"I walked through the entire building with 38 residents to let an aid know my friends oxygen was low and finally located one staff person in the kitchen who admitted they were the only one there."*
> *- Resident's Friend*

Many nurses leaving, or who intend to leave their positions, say that insufficient staffing and inability to provide quality care were two of the top reasons they are leaving. This impacts all nursing staff, including nurse aids, who provide the bulk of direct care in nursing home settings.

> *"I was the only aid on duty in a wing with 20 residents and had not completed cares when the charge nurse covering two wings told me I was done there for that shift. I had to come help in her wing. I was never allowed to go back and no one else was in there until shift change 3 hours later. I decided when I left it would be my last day there." - CNA*

Staffing insufficiency has existed without meaningful address for years. That already unstable foundation contributed to the collapse experienced when the COVID-19 crisis entered.

Ombudsmen themselves report being so conditioned by the pervasive and long-term staff-related problems that they have often failed to include the staffing code in cases as appropriate.

The program has identified adding staffing as a complaint when appropriate as an area for improvement in the coming year. Because of this, the program's overall complaint resolution rate may lower next year.

It is difficult for Ombudsmen to resolve complaints around staffing without other stakeholders fulfilling their roles as well.

- Owners must invest in their business for long term success.
- Administrators and operators must be prepared to provide effective leadership and oversight.
- Staff in all positions must be trained and properly supported to operate with integrity and hold each other accountable in the various important roles they play.
- Regulators must effectively survey and cite staffing deficiencies.
- Legislation requiring minimum, meaningful staffing is needed.

Transparency and accountability of current expenditures is needed to address proper funding ongoing.

To ensure Kansas is a good place to live and work, for all generations, this issue must be expediently and ethically addressed. Accountability, transparency, and creative collaboration with real investment from private and public sectors is essential. Continuing to look away is morally unacceptable.

Issues

Resident Rights

256 COMPLAINTS INVOLVING AUTONOMY, CHOICE, RIGHTS, PRIVACY

Individual conversations and observations in homes provide evidence to the Ombudsman that resident rights are being violated at even higher rates than complaint numbers reflect. Ombudsmen help residents be aware they have specific "resident rights," in addition to the human rights we all share. Still, residents are less willing to allow Ombudsmen to address resident rights issues than in years before the pandemic. The resident will discuss the concerns, and Ombudsmen can provide information that is often helpful to the resident, but they do not want any action taken on their behalf. There are many reasons for this. Most commonly, residents express a greater fear of retaliation. But they also fear having a staff member get in trouble or hurting their feelings; they have more critical or even urgent care needs they prefer to focus on as a priority; or have lost hope and have given up. These types of complaints should be easy to resolve, but that is not always the case. Ombudsmen are finding some administrators and operators are not familiar with resident rights. Regulations state Administrators and Operators "shall promote and protect" each resident's rights. But policies created by some owners and management from outside the facility put administrators and operators at odds with their employer's errant policy and their duty to protect rights and follow regulations.

Examples of complaints addressed: *A resident voiced not being allowed to have private phone conversations when they were required to take calls at a nurse's station. With the resident's consent, the Ombudsman could talk to the administrator and secure a designated room with a phone where this resident (and others) could make or receive calls privately.*

A resident who smoked and was recently admitted to a facility was told they could not smoke. With consent of the resident, the Ombudsman contacted social service staff to request a copy of the smoking policy and any assessments. While the facility asserted they recently became a smoke-free campus, and only residents admitted prior to that date could use designated areas to smoke, they acknowledged the policy was not provided to the resident prior to admission. Ultimately, the facility agreed this resident was able to smoke, and would be assessed for any needed support to do so safely.

A resident spoke with the Ombudsman regarding a roommate with different sleep preferences who had the tv playing all night long. With the resident's consent, the Ombudsman talked to the roommate. The roommate stated they were disturbed by activity in the room during the day, which was his preferred sleep time. Working with staff and residents within the home, they were able to find better matches for both roommates' schedules and those individuals agreed to transfer to other rooms supporting all parties needs more favorably.

An individual complained they were not allowed into a facility to visit a resident they had lived with for several years prior to the resident's admission to the facility. The Ombudsman made a visit to see the resident and, with the complainant's permission, let them know the woman had contacted our office. The resident advised there was a strained relationship between the party, who had been his girlfriend, and his children. While he said he would like to see the woman, his preference was not to upset his children. He did not wish for the Ombudsman to broach his wishes with his children. He advised that his choice was to discontinue the relationship and not have her visit. The Ombudsman reminded the resident it was his right to choose who he does and does not see. The Ombudsman also told him that he could reach out to our office if he changed his mind, and his choice was not supported. The facility understood they were to support his wishes.

Issues

Abuse, Neglect and Exploitation

115 Complaints Abuse Neglect Exploitation

- Some facility staff do not recognize actions that constitute neglect or abuse.
- Some facility staff do not recognize symptoms that can indicate neglect or abuse.
- Some staff report to Ombudsmen they do not know protocols for reporting abuse or neglect.
- Some staff report taking incidents to directors of nursing or administrators who do not take action, or worse, try to discredit the reporter.
- Some homes fail to make the required self-reports to Kansas Department for Aging and Disability Services (KDADS) and in some cases, when they do report to KDADS, they still fail to make required reports to law enforcement.
- There is often no revision of the care plan to reflect changes to the resident's medical, nursing, physical, mental, or psychosocial needs or preferences as a result of an incident of abuse.

We recommend that a standardized and comprehensive training for prevention, recognition, reporting and address of ANE be constructed. Further, that the training fulfilling federal ANE in-service requirements, and specific to state laws, be required and provided through a web-based platform housed with KDADS. An easy sign-in with a photo taken during the training with record of successful completion. Recorded for all staff working in an adult care home and on an annual basis. This provides for updates to regulation or law and provides that corporations operating in multiple states are not providing inaccurate information based on differences that may exist in state law.

"I would agree 100%. Especially if it was a KDADS online program, It would simply ensure the program is educated correctly with no misinformation. I'd back that idea anytime and twice on Sunday! I wish more in-service topics were standardized through KDADS for in-service resources."
- Kansas Nursing Home Administrator

Recognizing and reporting to address ANE is important, but prevention is key.

Individuals who live in adult care homes (in fact, people who live anywhere) do best when they have a voice and a choice about their daily lives. Individuals have a better quality of life when the people who care for them know them, know what is important to them, are familiar with their relationships, understand their culture and identity, respect their belongings, and know the things they like to do, as well as their preferred daily routines.

Education and training in person-centered thinking, planning and practice builds a culture of prevention and identification of abuse, neglect and exploitation. It also builds a culture that supports trauma-informed care when a incident does occur. The Ombudsman program is committed to assisting the building of that culture.

Education is one function of the Long-Term Care Ombudsman Program.

Issues

Person-Centered Care

Person-Centered Care is a requirement for nursing homes. There continues to be a lack of understanding about what that means, and thus lack of implementation in practice. Ombudsmen work with providers of long-term care services to promote a culture of person-centered living and respect for resident rights.

In 2022, Office of the State Long-Term Care Ombudsman was able to use special Older American Act grant funding to incorporate a part-time Training Coordinator position to provide information and education on Person-Centered Practices. The Center for Medicare and Medicaid (CMS) Final Rule for Nursing Facilities provide definition of and requirements for nursing facilities to provide residents with person-centered care. **Person-Centered Care** is defined in nursing home regulation as: **"to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives."** Person-Centered Practices and Care not only increases and supports resident choice and control, but also decreases the likelihood of abuse and neglect.

A Training Coordinator was hired based on experience in providing consultation and training in Person-Centered Practices and is a certified Mentor Trainer through The Learning Community for Person-Centered Practices.

Since January 2022, the Training Coordinator has offered 26 virtual training sessions that are available for residents, family members, Ombudsman, Adult Protective Service staff, nursing home staff, and other interested parties to attend for the purpose of introducing the foundational concepts and skills of Person-Centered Practices. All sessions have had representation from all of the aforementioned categories, as well as, professionals from six other states. A total of 395 participants were confirmed in attendance in these virtual education events. Some events were viewed by teams using one device; this only counted as one participant.

The training coordinator also provided additional training and support to increase Person-Centered Practices specifically within in the LTCO. The Office took a more mindful approach to Person-Centered Practices within team meetings and implemented use of individual employee and team One Page Descriptions.

The training sessions repeated throughout 2022 included:

- Person-Centered Thinking Skills Introduction
- One Page Descriptions for Healthcare Emergencies
- Person-Centered Transition Planning
- Person-Centered Care for People Who Experience Dementia

The Ombudsman program provides community education about our role and long-term care issues. Individuals interested in learning more, or who wish to register for virtual trainings, can do so by going to the Kansas Long-Term Care Ombudsman website: ombudsman.ks.gov.

Issues

Involuntary Discharges

Federal regulations allow facilities to initiate discharges of residents only in specific instances. Despite these protections, discharges that violate Federal regulations continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Program. A nursing home is required to provide a written, 30-day notice of involuntary discharge for any discharge not initiated by the resident. The nursing home is required to provide a copy of the notice to the State LTCO, and the notice must include specific elements, including information about the resident's appeal rights.

State-licensed adult care homes, like assisted living, residential health care, and home plus facilities, also must give written 30-day notice, but currently there is no requirement to provide a copy to the State LTCO or to allow for appeal rights. This places residents in those settings at increased risk.

There are many homes that rarely find reason to issue a notice of involuntary discharge. There are also facilities who are “serial offenders,” some who fail to provide the required written notice at all, others not providing appropriate reason or rationale. In many cases, the underlying problem is a symptom of other issues: lack of staff or other capacity to care for people with complex behavior or mental health needs. Providers often lack appropriate training and education in person-centered practices to support “a person who is experiencing difficulty.” Instead, they apply an improper label of “a difficult person.”

Increasingly, some facilities that advertise as memory care providers attempt to assert common behaviors associated with dementia, like becoming lost and entering others’ rooms, pacing, being nervous and agitated, as being a danger to others, instead of a recognized need to plan support. Ombudsmen often observe environments contributing to confusion or disorientation for these residents. Providers are often not assessing and creating plans around what works and what does not work for the individual. They often do not provide supervision as needed or involve the person in daily activities they can participate in positively. There is a failure to reassure the person as often as needed throughout the day, identify times a person is most likely to exhibit anxiety, agitation, and restlessness, and plan preferred activities during that time. Often there is a failure to ensure basic needs are met, including toileting, nutrition, and hydration. In most instances where a person is labeled as difficult, or even dangerous, they simply were communicating an unmet need through behaviors. Providers should have the proper capacity and competency to meet such needs, or they should not be allowed to accept new admissions.

Providers are required to provide a proper written reason and rationale for any involuntary discharge, and appeal rights should be available for residents in ALL long-term care adult care facilities; nursing homes, assisted living facilities, home plus, residential care facilities, and boarding care homes. It is a reasonable expectation that facilities be required to understand and follow the rules of the business they chose, and to be accountable for the service they make agreement to provide, which is paid for with hard-earned life savings or by tax dollars.

Issues

Right to Visitation, Communication, and Interaction—Guardianships

Common complaints from people under guardianship continue to include:

- The desire to live in their community of choice, rather than the guardian choice,
- Inappropriate restriction of visitors and friends by the guardian,
- Restriction on the ability to go places they want to go (guardian restricts the ability to leave the premises),
- The guardian does not know the person, never visits, and makes choices without including the person in the process, and/or,
- The guardianship was sought and became permanent for a temporary situation often for the convenience of hospitals to facilitate discharge plans contrary to the person's choice or necessity.

Meaningful education about a guardians role and all viable options for less restrictive adult decision making options should be cultivated and available to the community at large.

Supported Decision-Making is one less restrictive option, where people keep their rights and their decision-making capacity. Instead of having a guardian, people have supporters who help them make their own choices.

Adoption of the UNIFORM GUARDIANSHIP, CONSERVATORSHIP, AND OTHER PROTECTIVE ARRANGEMENTS ACT in Kansas would provide meaningful notice of peoples' rights and how to assert them. Too often, Ombudsman meet people subject to guardianship without having been provided proper notice or real opportunity to address the court.

When deemed necessary to institute such a serious action as guardianship, there would also be provisions that require involving individuals subject to guardianship in decisions about their lives, requirements that guardians create person-centered plans, and provisions to facilitate court monitoring of compliance with those plans.

Misuse of Antipsychotic Medications

Physicians are often asked to prescribe drugs to manage agitation and other behaviors instead of first providing non-pharmacological interventions through person-centered care.

Residents and families are not always made aware of the dangers of these drugs. Written informed consent should be required before administering these potentially dangerous drugs.

Nursing home residents erroneously diagnosed with schizophrenia are at risk of poor care and prescribed inappropriate antipsychotic medications. Antipsychotic medications are especially dangerous among the nursing home population due to their potential devastating side effects, **including death.**

High-quality training improves communication between caregivers and individuals living with dementia, provides for a reduction in dementia-related behaviors, and increases job satisfaction for staff. Expanded opportunities for learning should be encouraged and supported.

Issues

Dietary Complaints

Complaints have increased 33%

Common verified examples included food served cold, food not served or not served timely. On site observation, and photos of food demonstrated burnt food, sandwiches with contents unidentifiable, no meat, or in portions that did not cover the bread, or with mold.

Others where specific requirements for the resident's diet were not in the plans of care nor provided. Resident preferences per food were not supported. Family or friends were expected to supplement food preference as simple as having fruit in the form of a banana or orange. One resident who admitted known to have a vegan diet was required to purchase their own food. Their simple request for black beans and chick peas and was denied.

One administrator cited the corporate office limited charges to $500 a month on a credit card for all allowable expenses. Multiple entities report food purchases must go through a specific vendor contracted through their corporation. If items are not delivered by the vendor, there was no means to purchase ingredients to allow the cooks complete recipes for items on the menu. Residents, family members, and even staff, report paying for food out of their own pocket, without reimbursement.

One avenue ombudsman utilize to work with residents to address facility wide issues, of any type, is through **resident or family councils**. Resident and Families have the right to both organize and participate in resident groups without the facility interfering. Additionally a facility is required to address any grievances raised in councils, and decisions must be discussed with the resident/family group. The facility's decision and the rational must be documented and available for review.

Grilled Cheese and Onion Sandwich

With regard to food, reasonable efforts to accommodate the residents' choices and preferences must be made by the facility, as this helps ensure that residents are offered meaningful choices for their meals/diets that are satisfying to the residents as well as nutritionally adequate. Often multiple residents are experiencing similar frustrations. If direct communication with facility administration fails to gain the desired results a complaint may be made to survey, certification and licensing and resident council minutes would reflect if grievances are addressed and help surveyors determine if the facility is in compliance.

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Issues

Sufficient Capacity of Survey Certification & Credentialing in Surveyors, Other Staff, or Resources is Necessary to Fulfill Their Responsibilities

Deputy Secretary for Aging and Commissioner for Survey Certification and Credentialing meet with State Long-Term Ombudsman have regular meetings. Robust communication occurs and a true intent to fulfill each of our roles is not questioned.

Best of intent is not able to overcome issues related to lack of capacity:

- The KDADS complaint intake line is often not answered. Callers to the “hotline” are forced to leave voicemail messages and frequently have been reporting to our office they wait days for a return call.
- We find intake does not pass on relevant information provided by the reporter to the surveyors.
- Surveyors often appear to demonstrate a lack of understanding of basic tenants of regulation, person-centered care, and resident rights. Resident rights violations are a high source of complaints, but often are not recognized and assigned at intake and are rarely cited. Nurse-only survey teams in Kansas influence what type of complaints get cited. While nursing expertise is essential and critical to care complaints, there is value to other perspectives. Our office recommends that Kansas add non-nursing professionals to the survey teams and consider models of mixed professionals for regional teams.
- The survey process itself is not person (resident) focused, facility records are reviewed while resident logs or photos, or other evidence are not valued equally.
- Inspections of some new state-licensed settings have gone over 18 months with no state surveyor ever having been on site.
- Complaint inspections, even with allegations of serious ANE, are sometimes delayed or held until the next annual survey.
- The survey does not utilize photographs as evidence in conducting their investigations.
- In FY 2022, only 6 CNAs in Kansas were substantiated and put on the registry to prevent working with other vulnerable populations. The previous year that number was even less. Surveyors in Kansas conduct ANE investigations for that purpose, whereas many states utilize APS. *For this identified issue specifically, our office recommends a legislative post audit to assess the multiple processes, or lack of process, that allow perpetrators to continue to work with potentially vulnerable persons.*
- Residents and other reporters state they are not being contacted by surveyors when their complaints are investigated. They say they "never hear back" on the report they made so they are unsure if any investigation occurred and are not notified of a finding.
- Once an annual survey is at a certain stage, surveyors have not been allowed to accept a "new complaint" while still on site.

There is significant effort on the part of survey staff in ever more difficult conditions, but overall the state survey agency does not appear to have adequate capacity in numbers of surveyors, other staff, or resources to fulfill all their responsibilities.

When adequate regulatory oversight is not present it impacts the Ombudsman program’s ability to resolve issues for residents.

Issues

Sufficient Capacity of Office of Long-Term Care Ombudsman in Ombudsman, Other Staff, or Resources.

LTC Ombudsman work has become more complex and more taxing in recent years. The “corporate culture” in nursing homes is less collaborative and on-site administrators often abdicate their responsibilities to off-site management .

Infection protocols require more time during visits and communication is hampered. Individuals require more time to adequately feel heard given the more severe situations occurring. Ombudsman have experienced their own illness and felt the loss of excess numbers of residents due to COVID-19 and excess non-COVID-19 deaths.

Residents express more fear of retaliation and Ombudsmen have to address greater instances of interference with the duties of their work.

There continues to be amplified demands and responsibilities. The aging population continues to increase in number, while the number of Ombudsmen to serve them has not.

The National Academy of Sciences Institute of Medicine, in 1995, recommended one full-time equivalent (FTE) paid Ombudsmen per every 2000 long-term care (LTC) beds. Kansas’ paid Ombudsman ratio is one for every 4910 beds.

The Older Americans Act requires the State agency (KDADS)-provide for adequate legal counsel for the program (LTCO) that has competencies relevant to the legal needs of the program and of residents and is *without conflict of interest*. The program lacks adequate and conflict-free legal counsel.

Current funding level supports filling seven of what was nine full-time Regional Ombudsmen positions.

Ombudsmen cover all 105 counties and over 700 homes.

Through the pandemic, 2020 to date, the LTCO experienced a 75% loss in volunteers, further reducing critical Ombudsman resources to residents.

One-time COVID-19 funding is allowing for temporary staff:

- 2021 to present—Special Projects Ombudsman
- 2022 to present—Part-time Person-Center Practices Trainer
- 2nd half of 2023—Three part-time interns are to provide support for access to state licensed homes, provide information and assistance and build resident/family councils

Once COVID-19 funding is depleted in 2024, there will be significant risk of capacity to maintain required program activities.

Advocacy, Associations, and Coordination Activities

Kansas Senior Care Task Force

Senior Care Task Force - Quality of Care and Protective Services Working Group

Senior Care Taskforce - Workforce Subgroup

APS Advisory Council

KDADS CARE Advisory Council

Kansas Nursing Home Stakeholders Group

CNA Course Sponsor and Clinical Settings Workgroup

CNA Curriculum Committee

CMA Curriculum Committee

Steering TEAM Adult Decision Making – APS

DCF PPS APS Learning Collaborative group

PEAK 2.0 Advisory Board

Judicial Council

- **Advisory Committee on Adult Care Home Involuntary Discharge Appeals Meeting**
- **Guardianship & Conservatorship Committee**

KDADS Survey Certification and Credentialing Bi-Monthly

KDADS OOA /LTC Ombudsman Quarterly Meeting

Kansas Community of Practice –Charting the Life Course

Kansas Advocates for Better Care

HCBS Final Rule

Legislative Testimony

Media - Print, Digital, TV, Radio, Podcast , Social

National Consumer Voice

National Association State Ombudsman Programs

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* This list is provided as an example of the activities and coordination of the LTCO office and is not necessarily a comprehensive list.

Program Staff

JUSTIN ERK
Region 1 Long-Term Care Ombudsman

Barton, Dickenson, Ellsworth, Harvey, Marion, McPherson, Ottawa, Reno, Rice & Saline Counties

NECHELLE WHITE
Region 2 Long-Term Care Ombudsman

Atchison, Brown, Chase, Clay, Doniphan, Douglas, Geary, Jackson, Jefferson, Lyon, Marshall, Morris, Nemaha, Osage, Pottawatomie, Riley, Shawnee, Wabaunsee & Washington Counties

CHRISTINE MOZINGO
Region 3 Long-Term Care Ombudsman

Johnson, Wyandotte & Leavenworth Counties

MARILYN RANDA
Region 4 Long-Term Care Ombudsman

Butler, Cowley, Harper, Kingman, Sedgwick & Sumner Counties

KATIE ROSS
Region 5 Long-Term Care Ombudsman

Barber, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearney, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Scott, Seward, Stafford, Stanton, Stevens & Wichita Counties

VELVET UNREIN
Region 6 Long-Term Care Ombudsman

Cheyenne, Cloud, Decatur, Ellis, Gove, Graham, Jewell, Lincoln, Logan, Mitchell, Norton, Osborne, Phillips, Rawlings, Republic, Rooks, Rush, Russell, Sheridan, Sherman, Smith, Thomas, Trego & Wallace Counties

GINA ELLIOTT
Region 7 Long-Term Care Ombudsman

Allen, Anderson, Bourbon, Chautauqua, Cherokee, Coffey, Crawford, Elk, Franklin, Greenwood Labette, Linn, Miami, Montgomery, Neosho, Wilson & Woodson Counties

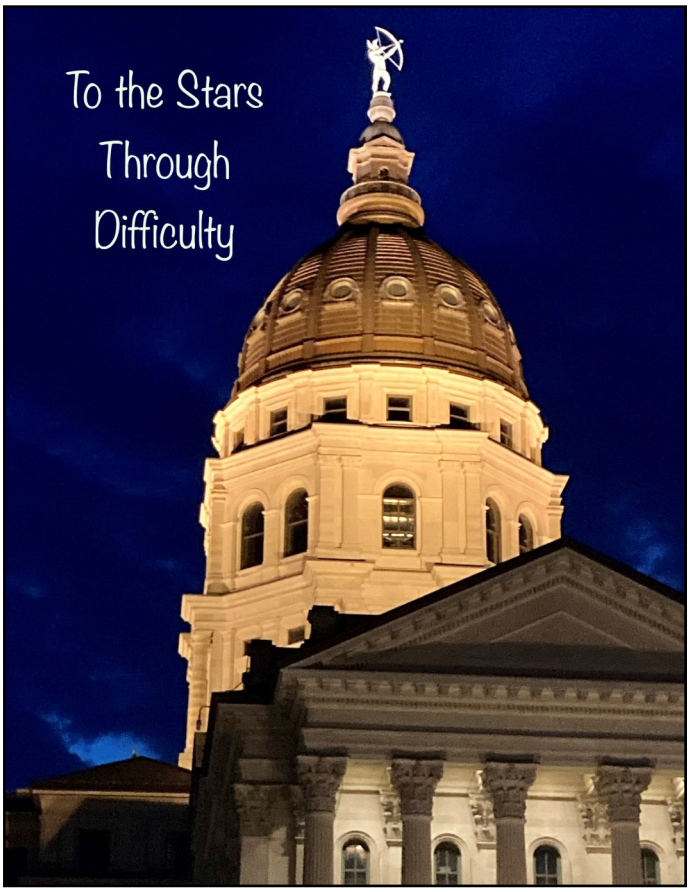
State Office Staff

CAMILLE RUSSELL
State Long-Term Care Ombudsman

BARBARA HICKERT
Special Projects Ombudsman

REBECCA ATNIP
Administrative Specialist

TAMMY COSTLOW
Training Coordinator Person-Centered Practices



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